Fax completed form to designated gene therapy fax (833) 910-1625
For Urgent requests please outreach to Cigna Gene Therapy Program at (855) 678-0051 or email to GeneTherapyProgram@Cignahealthcare.com

Gene Therapy
Hemgenix®
(etranacogene dezaparvovec-drlb intravenous infusion)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations, we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items under physician and patient information are completed.		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

FACILITY BILLING INFORMATION FOR PAYMENT SUPPORT

Billing Office Contact Name: Billing Office Phone:

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Request Detail:

ICD10: HCPCS Code

NDC: Additional Comment:

Where will this medication be obtained?
☐ Accredo
☐ Other (please specify):
☐ Physician's office stock (billing on a medical claim form)

Facility and/or doctor administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Hospital Outpatient
☐ Other (please specify):
☐ Physician's Office

What is the indication or diagnosis?
☐ Hemophilia B
☐ Other

Clinical Information. **Documentation is required for use of this gene therapy. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information.**

Check all that apply:

☐	Patient is male *Specified gender is defined as follows: males are defined as individuals with the biological traits of a man, regardless of the individual's gender identity or gender expression.*
☐	Patient is ≥ 18 years of age
☐	Prescribing physician attests that patient has not previously received Hemgenix
☐	Prescribing physician attests that patient has not previously received Beqvez
☐	Patient has moderately severe or severe hemophilia B as evidenced by a baseline (without Factor IX replacement therapy) Factor IX level ≤ 2% of normal **[documentation required]**
☐ i. ☐ ii.a. ☐ ii.b. ☐ iii.a. ☐ iii.b.	Patient meets ONE of the following (i, ii, or iii): i. According to the prescribing physician, the patient has a history of use of Factor IX therapy for ≥ 150 exposure days ii. Patient meets BOTH of the following (a and b): a. Patient has a history of life-threatening hemorrhage b. On-demand use of Factor IX therapy was required for this life-threatening hemorrhage iii. Patient meets BOTH of the following (a and b): a. Patient has a history of repeated, serious spontaneous bleeding episodes b. On-demand use of Factor IX therapy was required for these serious spontaneous bleeding episodes
☐ i. ☐ ii.	Patient meets ALL of the following (i, ii, and iii): i. Factor IX inhibitor titer testing has been performed within 30 days **[documentation required]** ii. Patient is negative for Factor IX inhibitors **[documentation required]**
☐ i. ☐ ii.	Patient meets BOTH of the following (i and ii): i. Patient does not have an active infection with hepatitis B virus or hepatitis C virus **[documentation required]** ii. Patient is not currently receiving antiviral therapy for a prior hepatitis B virus or hepatitis C virus exposure **[documentation required]**
☐	According to the prescribing physician, the patient does not have uncontrolled human immunodeficiency virus infection
☐ i. ☐ ii. ☐ iii. ☐ iv.	Patient has undergone liver function testing within 30 days and meets ALL of the following (i, ii, iii, and iv): i. Alanine aminotransferase level is ≤ two times the upper limit of normal **[documentation required]** ii. Aspartate aminotransferase level is ≤ two times the upper limit of normal **[documentation required]** iii. Total bilirubin level is ≤ two times the upper limit of normal **[documentation required]** iv. Alkaline phosphatase level is ≤ two times the upper limit of normal **[documentation required]** Date of completed lab(s):
☐	Patient does not have evidence of advanced liver impairment and/or advanced fibrosis
☐	Within 30 days, the platelet count was ≥ 50 x 109/L **[documentation required]** Date of completed lab(s):
☐ i. ☐ ii.	Within 30 days, patient meets ONE of the following (i or ii): i. Patient has an estimated creatinine clearance ≥ 30 mL/min **[documentation required]** ii. Creatinine level is ≤ two times the upper limit of normal **[documentation required]** Date of completed lab(s):
☐	The medication is prescribed by a hemophilia specialist physician
☐	Current body weight has been obtained within 30 days **[documentation required]** Date obtained:
☐	Prior Receipt of Gene Therapy
☐	Patient with a History of Factor IX Inhibitors

If any of the requirements listed above are not met and you feel administration of the requested gene therapy is medically necessary, please provide clinical support and rationale for the use of this gene therapy.

Additional pertinent information: (including recent history and physical, recent lab work, disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently)

Additional CPT and/or Administration Codes for Billing.

☐ Other

Agreement and Attestation:

Do you and your patient agree to share any required plan specific outcome measures? ☐ Yes ☐ No

I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Coverage Policies online at cigna.com.

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 Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005